IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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July 9, 2008

Teresa Carpenter
Preferred Community Homes Courtyard
615 Second Avenue West
Wendell, Idaho 83355

Provider #13G057

Dear Ms. Carpenter:

On **July 2, 2008**, a Complaint Survey was conducted at Preferred Community Homes Courtyard. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003653

Allegation #1: Individuals are being punished with time out.

Findings: An unannounced complaint investigation was conducted at the facility from 6/27/08 to 7/2/08. During that time, observations, record reviews and interviews were conducted.

The facility's "Behavior Method Hierarchy and Definitions" policy, revised 7/27/07, stated under "Time Out: A consequence in which positive reinforcement is withdrawn for a pre-specified period of time following the performance of maladaptive behavior..." The definition of "Exclusionary time out" was "a procedure in which the individual is removed from the reinforcing environment for a specific period of time." The policy stated "Any of the described methods listed may be used in accordance with federal and state regulations. It will be written in a formal behavior program and Guardian and HRC {Human Rights Committee} consent will first be maintained {sic}. {Facility's name} does not tolerate the usage of any behavioral method not outlined above (i.e. {sic} time out rooms) under any circumstances."

During an environmental observation on 6/27/08 at 1:30 p.m., a small yellow chair was noted to be in one individual's room.

When asked about the chair, the Administrator, who was present at the time of the observation, stated the individual would sit in the chair to calm down. Another individual had a grey chair in his room by his bed. The walls and the area near the bed were covered with padding. When asked about the area, the Administrator, who was present at the time of the observation, stated the individual would sit in the chair to calm down. She stated the padding was in place because the individual would sometimes hit his head while sitting in the chair.

The behavioral interventions of 8 individuals were reviewed. The plans of 2 individuals included instructions for staff to take them to a safe environment and sit quietly for 10 minutes. When asked, staff stated on 6/27/08 at 2:10 p.m., one individual's quite place was in her room, sitting in the yellow chair. The other individual's quite place was in his room in the grey chair.

Human rights committee approvals and guardian consents were reviewed for the 2 individuals. One of the individual's written informed consent did not include information related to taking the individual to a safe environment and sitting quietly for 10 minutes.

When asked, during an interview on 7/1/08 at 3:00 p.m., if information related to the time out procedure should be included in the written informed consent, the QMRP stated it should.

It could not be determined that the time out procedures were being used in an inappropriate, punishing manner. Therefore the allegation was unsubstantiated due to a lack of sufficient evidence. However, there was not sufficient information provided to the guardian in the written informed consent and the deficient practice was cited at W124.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff are physically, verbally and psychologically abusive toward individuals and staff do not reinforce positive behaviors.

Findings: An unannounced complaint investigation was conducted at the facility from 6/27/08 to 7/2/08. During that time, observations, record reviews and interviews were conducted.

The facility's policy for "Abuse, Neglect, Mistreatment and Injuries of Unknown Source," revised 5/30/08, stated "Employees must not use physical, verbal, sexual, or psychological abuse or punishment." The definitions section of the policy stated "Emotional or Psychological Abuse: The verbal or non-verbal infliction of anguish, pain, or distress that results in mental or emotional suffering. Includes, {sic} but is not limited to humiliation, harassment and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma." The facility's policy for "Resident Rights," undated, stated "As an employee you must ensure that the rights of our residents are protected at all times..." The policy further stated individuals' rights included "The right not to be subjected to physical, verbal, sexual or psychological abuse or punishment."

The facility's incident reports, investigations, staff personnel records, and staff communication log, from 1/08 to 6/26/08, were reviewed. None of the records contained any documentation of incidents of abuse toward individuals. Additionally, nursing notes and quarterly body check sheets from 1/08 to 6/26/08 were reviewed for 8 individuals. The records did not include documentation of abuse or suspicious injuries of unknown origin.

Observations were conducted at the facility on 6/27/08. Staff were not observed to interact with individuals in an abusive and/or demeaning manner and no suspicious injuries were observed on any of the 8 individuals residing at the facility. Staff were noted to verbally reinforce individuals by saying "good job." Additionally, on 6/27/08 and 6/28/08, 12 direct care staff who were working or had worked at the facility were interviewed. All staff stated they had been trained on the facility's Abuse policy during their orientation. Additionally, 2 senior staff members stated that the policy was periodically reviewed during staff meetings. When asked, all of the staff interviewed stated they had not witnessed or heard of the individuals being abused and/or demeaned by staff. When asked about reinforcement, all staff interviewed stated individuals were verbally reinforced throughout the day. Staff also stated high fives were given as reinforcement to the individuals residing at the facility.

Through observations, interviews, and record reviews, it could not be established that staff had been physically, verbally, or psychologically abusive toward the individuals residing at the facility. Therefore, the allegation was unsubstantiated due to a lack of evidence.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: When an individual takes food he is removed from the table and made to sit on the couch. He is not allowed to get up and have dinner and has to sit and watch everyone else eat.

Findings: An unannounced complaint investigation was conducted at the facility from 6/27/08 to 7/2/08. During that time, observations, record reviews and interviews were conducted.

On 6/27/08 at 12:05 p.m., the individuals residing at the facility were noted to be seated at the table eating lunch. When asked about mealtimes, staff stated during an interview on 6/27/08 at 3:10 p.m. that all of the individuals would sit at the table together for meals. Staff stated one individual sometimes took food that did not belong to him.

On 6/27/08 and 6/28/08, 12 direct care staff who were working or had worked at the facility were interviewed. When asked about the individual who took food that did not belong to him during meals, staff stated the following:

- When he takes food we ask him to put his hands down and replace the food.
- He is prompted to put his hands down and replace the food.
- He takes food approximately twice per week. We redirect him, pull his chair away from the table, clean up the mess, and re-serve him with a substitution. For example, if he took ham, we would take the ham and replace it with turkey bacon.
- We pull him away from the table and replace the food. It happens more than once a week but not everyday.
- We pull his chair away from the table, and replace the food. It happens every time he sits at the table.
- We make sure he does not choke, replace the food and offer him another sandwich or whatever he's eating.
- We let him know it's not okay.

The individual's IPP, behavior plans, and behavioral assessment were reviewed on 6/27/08. His behavior assessment stated he would "attempt to steal food and eat non-edible objects more often when he is hungry" and staff may have to occasionally "restrain his hands and arms to keep him from eating a non-food item or trying to swallow a handful of uncut food." No other information related to taking food was included in the documents. When asked about interventions related to the individual's food taking, the Administrator stated, during an interview on 7/1/08 at 3:00 p.m., the individual now had a plan in place.

When asked if the individual's behavioral assessment had been updated to include information related to food taking, the Administrator stated it had not yet been updated. When asked about the plan during a follow up interview on 7/2/08 at 9:00 a.m., the QMRP stated the plan had been implemented on 7/1/08.

Through observations, interviews, and record reviews, it could not be established that staff made an individual sit and watch others eat or withheld food from an individual.

Therefore, the allegation was unsubstantiated due to a lack of evidence. However, the facility failed to ensure an individual's behavior of inappropriately taking food was sufficiently addressed and the deficient practice was cited at W214.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Individuals are being subjected to inappropriate physical restraints/carries.

Findings: An unannounced complaint investigation was conducted at the facility from 6/27/08 to 7/2/08. During that time, observations, record reviews and interviews were conducted.

The behavior plans of 8 individuals residing at the facility were reviewed. Physical restraint was included as an intervention in 5 of the individuals' plans. The behavior slips from 1/08 to 6/26/08 were reviewed for those individuals. None of the behavior slips documented the use of inappropriate restraints. Additionally, on 6/27/08 and 6/28/08, 12 direct care staff who were working or had worked at the facility were interviewed. Staff stated they had not seen any inappropriate restraints.

On 6/27/08 at 1:58 p.m., staff was observed to carry an individual to the van. At that time, staff were asked why the individual was being carried. Staff stated the individual had foot surgery and needed to be carried because her foot sometimes bothered her.

Records were reviewed for the individual who was being carried and documented she had foot surgery. A staff communication log entry, dated 6/13/08, stated she was "wt. {weight} bearing as tolerated." Information related to how staff were to assist the individual (e.g. carry, assist to transfer, etc.) was not present in her record. When asked, on 6/27/08 at 2:00 p.m., if there were guidelines related to the individual's weight bearing or guidelines for transferring/carrying her, the Administrator stated there were not. The LPN also stated, when asked on 6/27/08 at 4:25 p.m., that guidelines for bearing weight as tolerated, had not been developed beyond the note in the communication log.

It could not be determined that individuals were subjected to inappropriate restraints. Therefore, the allegation was unsubstantiated due to a lack of sufficient evidence. However, the facility failed to ensure guidelines were developed to address the needs of an individual after foot surgery and the deficient practice was cited at W240.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: An individual is made to wear torn clothing.

Findings: An unannounced complaint investigation was conducted at the facility from 6/27/08 to 7/2/08. During that time, observations, record reviews, and interviews were conducted.

Observations were conducted on 6/27/08. During that time, individuals were observed to be wearing appropriate clothing which was in good repair. Direct care staff were interviewed on 6/27/08 and 6/28/08. Staff stated the following regarding items which were destroyed:

- If something gets torn we have them change and write what happened in the log. One individual's torn clothes get put in a bag and sent to his mom.
- We have them change. For one individual, we save it and give it to his mom.
- Anything that is destroyed or broken we take and throw it away.
- We bag whatever it is and give it to the Administrator.

The staff communication log was reviewed. An entry, dated 6/24/08 stated an individual had "been behavioral tonight he ripped his dragon shirt." When asked about the individuals' personal possessions on 6/27/08 at 6:05 p.m., the Administrator stated an updated inventory was done for one individual at his mother's request. She stated anytime he had clothes which were torn, the clothes were placed in a bag and sent to the individual's mother. The Administrator then took a bag from the office, untied it and showed the survey staff a torn shirt which was waiting to be sent to the individual's mother. Beyond that, the Administrator stated the facility did not keep personal possession inventories and they did not have an alternative system in place to track receipt and loss of the individuals' personal items.

It could not be determined that individuals were made to wear torn clothing. Therefore, the allegation was unsubstantiated due to a lack of sufficient evidence. However, the facility failed to ensure sufficient systems were developed and implemented to ensure the individuals' rights to retain and use appropriate personal possessions was upheld. The deficient practice was cited at W137.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/mlw

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July 9, 2008

Teresa Carpenter
Preferred Community Homes - Courtyard
615 Second Avenue West
Wendell, Idaho 83355

RE: Preferred Community Homes - Courtyard, Provider #13G057

Dear Ms. Carpenter:

This is to advise you of the findings of the Complaint survey of Preferred Community Homes - Courtyard, which was conducted on July 2, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 21, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by July 21, 2008. If a request for informal dispute resolution is received after July 21, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 07/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE W 000 INITIAL COMMENTS	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The surveyors conducting the survey were: Nicole Wisenor, QMRP, Team Leader Matthew Hauser, QMRP Jim Troutfetter, QMRP Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactivity Disorder IPP - Individual Program Plan LPN - Licensed Practical Nurse Mandt - A restraint system OCD - Obsessive Compulsive Disorder ODD - Oppositional Defiant Disorder QMRP - Qualified Mental Retardation Professional SIB - Self Injurious Behavior WIC - Written Informed Consent	W 000	"Preparation and implementation of this plan of correction does not constitute admission or agreement by Courtyard with the facts, findings or other statements as alleged by the state agency dated July 2, 2008. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Courtyard – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 4 of 4 individuals (Individuals #1 - #4) whose written informed consents were	W 124	**W 124 483.420(a)(2) PROTECTION OFCLIENTS RIGHTS** The Facility will ensure the rights of all clients. The facility will inform each client, parent, or legal guardian, of the clients medical condition, developmental And behavioral status, risks of treatment, And the right to refuse treatment. The clients BMP, the clients definitions of Behavioral Modification Methods, the List of side effects and the reason the medication is being prescribed , the list and description of Mandt techniques used Will all be attached to all WIC's. all clients WIC's will be reviewed and revised with all the accurate and correct information to ensure the deficient will not recur.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Carpenter | TITLE: Admin | (X6) DATE: 7/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	515 SECOND AVENUE WEST WENDELL, ID 83355

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W 124	Continued From page 1 reviewed. This resulted in a lack of information being provided to the individuals' guardians regarding restrictive interventions. The findings include: 1. Individual #1's 4/11/08 IPP stated he was diagnosed with mild mental retardation, ADHD, ODD, OCD, and pervasive developmental delay. His behavior intervention plan, revised 4/12/07, stated he engaged in behaviors which included aggression "(hitting, biting, pinching, scratching, kicking, head butting, and attempts to)," SIB (biting and headbanging) and threats to commit suicide. a. The aggression and SIB section of the behavior plan included instructions to staff which stated "Severely Aggressive [sic] behavior must be stopped immediately by removing [Individual #1] from the environment using Mandt techniques for 1 or 2 person moving restraint if necessary." However, Individual #1's WIC for the plan, dated 4/14/08, did not include information related to the restraint. When asked about the WIC, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated the information was not included in the WIC. b. The "Threats of suicide" section of the behavior plan included instructions to staff which stated "A room assessment is to be done to ensure that nothing that could be used to injure himself is in his room. The same assessment is to be done with the home. Any items that are potentially harmful are to be placed where [Individual #1] does not have access to them." However, Individual #1's WIC for the plan, dated 4/14/08, did not include information related to the restriction of items. When asked about the WIC,	W 124	To be completed by the QMRP and Behavioral Specialist by 09/21/08.	

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W 124	Continued From page 2 during an interview on 7/1/08 at 3:00 p.m., the QMRP stated the information was not included in the WIC. 2. Individual #2's 6/8/08 IPP stated he was diagnosed with profound mental retardation. His behavior intervention plan, dated 3/20/07, stated he engaged in behaviors which included self abuse (defined as biting himself and attempts to). The plan stated staff were to "follow the prompting hierarchy to get [Individual #2] to stop biting himself all the way up to Mandt technique for a bite release." The plan also stated if other interventions were ineffective, staff were to wrap the area on his hand that he was biting in such a manner as to allow him continued full use of his hand and fingers. However, Individual #1's WIC for the plan, dated 4/14/08, did not include information related to the bite release technique or the wrap. When asked about the WIC, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated the information was not included in the WIC. 3. Individual #3's 12/7/07 IPP stated she was diagnosed with profound autism. Her behavior plan, dated 1/7/08, stated she engaged in aggression (hitting, biting, pinching, scratching, kicking, head butting, and attempts to) and SIB (head banging, biting, hitting, and kicking). The aggression and SIB section of the plan stated "Staff may use Mandt techniques (physical assist to stand or sit & the walking/moving restraint) to assist [Individual #3] to an area away from others." The plan also stated Individual #3 was to sit in a chair for 10 minutes. During an environmental observation on 6/27/08 at 1:30 p.m., a small yellow chair was noted to be	W 124		

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W 124	Continued From page 3 in Individual #3's bedroom. When asked about the chair, the Administrator, who was present at the time of the observation, stated Individual #3 would sit in the chair to calm down. Individual #3's WIC, dated 1/7/08, did not include information related to having Individual #3 sit in a chair in her room for 10 minutes of calm. When asked about the WIC, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated the time out procedure was not addressed in the WIC. 4. Individual #4's behavior intervention plan, revised 10/4/07, stated she engaged in aggression (hitting, biting, pinching, scratching, kicking, head butting, and attempts to) and SIB (scratching self, hitting self, slapping self, pinching self, banging head, and attempts to). The plan stated if she attempted to bite others and/or was self abusive by hitting/slapping her head and head butting, staff were to have her wear a helmet until she was calm. The plan further stated if she was aggressive (pinching and scratching) staff were to have her wear mittens until she was calm. However, her 10/4/07 WIC for the plan did not include information related to the helmet and mittens. When asked about the WIC, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated the information related to the helmet and mittens was not included in the WIC. The facility failed to ensure sufficient information regarding the individuals' restrictive interventions were included in their WICs.	W 124		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during	W 130		

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W 130	Continued From page 4 treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure privacy was afforded to 2 of 8 individuals (Individuals #5 and #8) residing at the facility. This resulted in the individuals' right to privacy being violated. The findings include: 1. On 6/27/08 at 12:35 p.m. staff was observed assisting Individual #5 to change his incontinence brief in the bathroom with the door open. His shirt was on and his pant were pulled down around his ankles, exposing his genitals. At that time it was noted Individual #8 was sitting on the floor outside the bathroom door. On 6/27/08 at 12:40 p.m., staff was observed prompting Individual #8 to the bathroom. Staff then assisted Individual #8 to change his incontinence brief and use the toilet with the door open. While Individual #8 was using the toilet, Individual #5 was prompted to sit outside the open bathroom door. When asked about the observation, the QMRP stated during an interview on 7/1/08 at 3:00 p.m., "it will be fixed." The facility failed to ensure Individuals #5 and #8 were provided with privacy during the care of their personal needs.	W 130	**W 130 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS** The facility will ensure privacy during treatment and care of personal needs of all of the clients residing at Courtyard. All staff will be in serviced on privacy rights of clients observations will be done monthly with formal observations notes recorded, in services will be done quarterly and documented to ensure the deficient will not recur. To be completed by the Administrator, And the RSC by 08/31/08	
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients	W 137		

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W 137	Continued From page 5 have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, staff interviews, and record review, it was determined the facility failed to ensure sufficient systems had been developed and implemented to ensure individuals' rights to retain personal possessions was upheld for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the potential for individuals' possessions to be lost, stolen, or destroyed without appropriate interventions being implemented. The findings include: 1. On 6/27/08 and 6/28/08, direct care staff were interviewed regarding destruction of property. Staff stated the following regarding items which were destroyed: - If something gets torn we have them change and write what happened in the log. Individual #1's torn clothes get put in a bag and sent to his mom. - We have them change. For individual #1, we save it and give it to his mom. - Anything that is destroyed or broken we take and throw it away. - We bag whatever it is and give it to the Administrator. The staff communication log was reviewed. An entry dated 6/24/08 stated Individual #1 had "been behavioral tonight he ripped his dragon shirt." When asked about the individuals' personal possessions on 6/27/08 at 6:05 p.m., the Administrator stated an updated inventory was done for Individual #1 at his mother's	W 137	**W 137 483.420(a)(12) PROTECTION OF CLIENTS RIGHTS** The facility will ensure that each client living at Courtyard will have the right to retain and use appropriate personal possessions and clothing. The facility will put in place a formal Personal inventory sheet, that will include clothing items, misc items, it will include a add and delete section and the reason it was deleted. the inventory will be done at least quarterly, and anytime a client receives clothes such at Christmas time, birthday, and the start of school. Each client at Courtyard will have an inventory sheet to be kept in a binder in the office to ensure the deficient will not recur. To be completed by the Administrator, And the RSC by 09/21/08.	

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W 137	Continued From page 6 request. She stated anytime he had clothes which were torn, the clothes were placed in a bag and sent to his mother. The Administrator then took a bag from the office, untied it and showed the survey staff a torn shirt which was waiting to be sent to Individual #1's mother. Beyond that, the Administrator stated the facility did not keep personal possession inventories for the 8 individuals (Individuals #1 - #8) residing at the facility and they did not have an alternative system in place to track receipt and loss of the individuals' personal items. The facility failed to ensure sufficient systems had been developed and implemented to ensure individuals' rights to retain personal possessions was upheld.	W 137		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination for 8 of 8 individuals (Individuals #1 - #8) whose records were reviewed. That failure resulted in individuals not receiving the services and training required to meet their needs. The findings include: 1. Individual #8 was a 15 year old male. His 1/2/08 IPP stated he had autism and a history of maladaptive behaviors. His behavior assessment stated he would "attempt to steal food and eat	W 159	**W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL** Any individual under their idea body weight will be weighed weekly, and any client with a weight loss of five pounds or more will be assessed by the dietician. The LPN will notify the dietician and the QMRP of all clients weight at the end of every month, and weekly of any client that is on a weekly weight.	

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W 159	Continued From page 7 non-edible objects more often when he is hungry" and staff may have to occasionally "restrain his hands and arms to keep him from eating a non-food item or trying to swallow a handful of uncut food." Individual #8's dietary notes from 6/4/07 to 3/20/08 were reviewed and documented the following: 6/4/07: His weight was listed as 110 pounds in 3/07, 104 pounds in 5/07, and 102 pounds in 4/07. The notes stated his current weight was at 93% of his ideal body weight range (112-136 pounds) but his specific weight was not indicated. The dietician documented a slow weight gain was desirable and he was to receive second helpings on request. 9/27/07: His weight was listed as 99 pounds in 7/07, 96 pounds in 8/07 and 108.5 pounds in 9/07. The notes stated the weight loss was not desirable with his current weight at 96% of his ideal body weight range. The note further stated he was at an appropriate weight for his age and to monitor his weigh monthly. 3/20/08: His weight was listed as 111 pounds in 11/07, 115 pounds in 12/07, 110 pounds in 1/08, and 108 pounds in 2/08. His nursing notes stated some weight loss was noted and he was at 92% of his ideal body weight range and that slow weight gain was desirable. The dietician's recommendations included continuing meals and snacks three times daily, offer whole milk and higher calorie snacks to promote weight gain. When asked about Individual #8's current weight, the LPN stated, on 6/27/08 at 4:42 p.m.,	W 159	In order to ensure that the QMRP provides sufficient monitoring and coordination of the status of the Courtyard clients, the plan of correction for the following federal deficiencies listed under W 159 Will serve as the plan of action to ensure Individuals residing at Courtyard Will receive services and required Training to meet their developmental And behavioral needs. Please refer To W124, W130, W137, W193, W214, W227, W240, W289, and W290 for specific information Relating to those deficiencies. To be completed by QMRP, Behavioral Specialist, and Administrator By 09/21/08.	

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W 159	Continued From page 8 Individual #8's 6/08 weight was 106 pounds. When asked if the dietician had been notified of the weight loss, the LPN and QMRP stated no. When asked what criteria had been established which would trigger notification of the dietician, the QMRP stated the dietician would be notified if there were specific notification parameters established by the dietician or if there was a drastic change such as someone dropping below their ideal body weight range. The LPN stated Individual #8 was below his body weight range and the QMRP stated the dietician should be notified. The QMRP also stated the dietician was scheduled to come to the facility within the next couple of days. The QMRP failed to ensure Individual #8's dietary needs were adequately addressed. 2. Refer to W124 as it relates to the QMRP's failure to ensure sufficient information related to restrictive interventions was provided to the individuals' guardians. 3. Refer to W130 as it relates to the QMRP's failure to ensure individuals were provided with privacy during the care of their personal needs. 4. Refer to W137 as it relates to the QMRP's failure to ensure sufficient systems were developed and implemented to ensure the individuals' rights to retain personal possessions was upheld. 5. Refer to W193 as it relates to the QMRP's failure to ensure staff consistently demonstrated the skills necessary to consistently implement the individuals' behavior intervention strategies.	W 159		

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W 159	Continued From page 9 6. Refer to W214 as it relates to the QMRP's failure to ensure the individuals' behavior assessments included comprehensive information on which to base program decisions. 7. Refer to W227 as it relates to the QMRP's failure to ensure specific objectives and plans were developed to address the individuals' identified needs. 8. Refer to W240 as it relates to the QMRP's failure to ensure an individual's IPP was updated to include all relevant services and supports necessary to meet her identified needs. 9. Refer to W289 as it relates to the QMRP's failure to ensure all systematic behavioral interventions were incorporated into an individual's program plan. 10. Refer to W290 as it relates to the QMRP's failure to ensure standing or as needed interventions were not permitted.	W 159		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure staff demonstrated the skills and competencies to administer interventions for 2 of 8 individuals (Individuals #4 and #6) whose behavioral interventions were reviewed. This resulted in a lack of necessary equipment being available for staff to implement the individuals'	W 193	**W 193 483.430(e)(3) STAFF TRAINING PROGRAM** Staff will be able to demonstrate the skills and techniques that are necessary to administer interventions to manage inappropriate behavior of clients. Staff will be trained and in serviced on all behavior plans at Courtyard.	

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W 193	Continued From page 10 intervention strategies. The findings include: 1. Individual #4 and Individual #6's behavior plans stated the following: - Individual #4's behavior intervention plan, revised 10/4/07, stated she engaged in aggression (hitting, biting, pinching, scratching, kicking, head butting, and attempts to) and SIB (scratching self, hitting self, slapping self, pinching self, banging head, and attempts to). The plan stated if she attempted to bite others and/or was self abusive by hitting/slapping her head and head butting, staff were to have her wear a helmet until she was calm. - Individual #6's behavior intervention plan, revised 3/08 stated Individual #6 engaged in SIB (biting, hitting, head banging). The plan stated if he attempted to bang his head, staff were to use a helmet for up to 2 minutes. On 6/27/08 from 12:53 to 1:45 p.m. Individuals #4 and #6 were observed during a walk to the park and back to the facility. However, the helmets were not taken with the individuals. Additionally, on 6/26/08 at 2:50 p.m., staff stated Individual #4 and #6 were on an outing to another town. At that time it was noted Individual #6's helmets were on top of the entertainment center in the living room. When asked about the helmets the QMRP stated during an interview on 6/27/08 at 4:15 p.m., the Individuals should have their helmets available to them at all times. The facility failed to ensure staff consistently demonstrated the ability to effectively administer the helmet interventions for Individuals #4 and #6.	W 193	Two helmets, and Other adaptive equipment used To deal with client behaviors will be Made available for staff at all times. Equipment will be placed in the proper places, such as the vans. this will be done for all clients to ensure this deficient does not recur. To be completed by the QMRP, And Administrator by 09/21/08.	

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W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 8 of 8 individuals (Individuals #1 - #8) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's 4/11/08 IPP stated he was diagnosed with mild mental retardation, ADHD, ODD, OCD, and pervasive developmental delay. His behavior intervention plan, revised 4/12/07, stated he engaged in behaviors which included threats to commit suicide. The "Threats of suicide" section of the behavior plan included instructions to staff which stated if he threatened suicide he was to have 1:1 staff monitoring, a suicide assessment was to be completed and "A room assessment is to be done to ensure that nothing that could be used to injure himself is in his room. The same assessment is to be done with the home. Any items that are potentially harmful are to be placed where [Individual #1] does not have access to them." Individual #1's behavior assessment, dated 4/12/08, included sections titled "Impact of Daily Living (what does the behavior effect/restriction of rights, etc.)," and "Interventions (intervention needed to organize and direct the maladaptive	W 214	W 214 483.440(c)(3)(iii) **INDIVIDUAL PROGRAM PLAN** Behavioral assessments for All 8 clients residing at Courtyard will be re-assessed the behavioral assessments and the BMP's will be cross referenced to ensure that no pertinent information is missed, and that all comprehensive information is included. Then that information will be included in all 8 clients IPP. This will be done every time That there is a revision made To an assessment and yearly At the IPP meeting to ensure That this deficient will Not recur. To be completed by the QMRP, Behavioral Specialist, And the Administrator by 09/21/08.	

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W 214	Continued From page 12 behavior)." The sections did not include information related to Individual #1's threats of suicide. When asked about the assessment, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated the information was not included in the assessment but it should be. 2. Individual #2's 6/8/08 IPP stated he was diagnosed with profound mental retardation. His behavior intervention plan, dated 3/20/07, stated he engaged in behaviors which included self abuse (defined as biting himself and attempts to). The plan stated staff were to "follow the prompting hierarchy to get [Individual #2] to stop biting himself all the way up to Mandt technique for a bite release." Individual #2's behavior assessment, dated 4/12/08, did not include information related to the bite release technique. When asked about the assessment, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated the information was not included in the assessment but it should be. 3. Individual #5's 8/3/07 IPP stated in the "Social/Emotional Skills" section that he was "either very good with many happy sounds or very angry with a large amount of hitting (staff and occasionally other students) self injury [sic] (mostly biting the backs of his hands), and screaming. Occasionally, [Individual #5] will require medication to help him calm down." Additionally, his record included a "Mask Protocol," undated, which stated Individual #5 was to wear a mask and was to be removed from the table at mealtimes due to infection control	W 214		

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W 214	Continued From page 13 concerns caused by his spitting behavior. However, Individual #5's behavioral assessment, dated 8/3/07, stated the following: "Strengths: [Individual #5] is generally content in his environment. [Individual #5] rarely engages in inappropriate behavior. [Individual #5] is able to use some words to communicate. [Individual #5] is able to answer some Yes/No questions. [Individual #5] is able to request and protest using words and gestures [sic] [Individual #5] has independent eating skills [sic] [Individual #5] is compliant with verbal requests to stop undesired behaviors. [Individual #5] can follow one step instructions. Needs: No formal interventions needed at this time." When asked about the assessment, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated no additional information related to the function of Individual #5's behaviors was contained in his record. The facility failed to ensure Individual #5's functional assessment included comprehensive, consistent information related to his behavioral management needs. 4. Individual #8's 1/2/08 IPP stated he had autism and a history of maladaptive behaviors. a. Individual #8's IPP stated he received Tenex	W 214		

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W 214	Continued From page 14 (an antihypertensive drug) 2 mg 1 and 1/2 tablets each evening. His IPP further stated the psychotropic medication reduction plan for Tenex was based on Individual #8 averaging 8 hours of sleep per night for six consecutive months. However, Individual #8's behavioral assessment did not include information related to his sleep disturbances or what impacts they may have on his other behaviors. b. On 6/27/08 at 12:05 p.m., the individuals residing at the facility were noted to be seated at the table eating lunch. When asked about mealtimes, staff stated during an interview on 6/27/08 at 3:10 p.m., that all of the individuals would sit at the table together for meals. Staff stated Individual #8 sometimes took food that did not belong to him. On 6/27/08 and 6/28/08, 12 direct care staff who were working or had worked at the facility were interviewed. When asked about Individual #8 taking food that did not belong to him, staff stated the following: - When he takes food we ask him to put his hands down and replace the food. - He is prompted to put his hands down and replace the food. - He takes food approximately twice per week. We redirect him, pull his chair away from the table, clean up the mess, and re-serve him with a substitution. For example if he took ham, we would take the ham and replace it with turkey bacon. - We pull him away from the table and replace the food. It happens more than once a week but not everyday. - We pull his chair away from the table, and	W 214		

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W 214	Continued From page 15 replace the food. It happens every time he sits at the table. - We make sure he does not choke, replace the food and offer him another sandwich or whatever he's eating. - We let him know it's not okay. Individual #8's IPP, his 10/2/06 behavior plan, and his 1/2/08 behavioral assessment were reviewed on 6/28/08. His behavior assessment stated he would "attempt to steal food and eat non-edible objects more often when he is hungry" and staff may have to occasionally "restrain his hands and arms to keep him from eating a non-food item or trying to swallow a handful of uncut food." No additional information related to taking food was included in the documents. When asked about interventions related to Individual #8's food taking, the Administrator stated, during an interview on 7/1/08 at 3:00 p.m., Individual #8 now had a plan in place. When asked if his behavioral assessment had been updated to include information related to food taking, the Administrator stated it had not yet been updated. When asked about the plan during a follow up interview on 7/2/08 at 9:00 a.m., the QMRP stated the plan had been implemented on 7/1/08. The facility failed to ensure Individual #8's functional assessment included comprehensive, current information related to his behavioral management needs. 5. Individual #3's 12/7/07 IPP stated she was diagnosed with profound autism. Her behavior plan, dated 1/7/08, stated she engaged in aggression (hitting, biting, pinching, scratching, kicking, head butting, and attempts to) and SIB (head banging, biting, hitting, and kicking). The	W 214		

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W 214	Continued From page 16 aggression and SIB section of the plan stated "Staff may use Mandt techniques (physical assist to stand or sit & the walking/moving restraint) to assist [Individual #3] to an area away from others." The plan also stated Individual #3 was to sit in a chair for 10 minutes. During an environmental observation, on 6/27/08 at 1:30 p.m., a small yellow chair was noted to be in Individual #3's bedroom. When asked about the chair, the Administrator, who was present at the time of the observation, stated Individual #3 would sit in the chair to calm down. Individual #3's behavioral assessment, dated 1/8/08, did not include information related to having Individual #3 sit in a chair in her room for 10 minutes of calm. When asked about the assessment, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated the assessment did not include information related to the time out procedure. The facility failed to ensure Individual #3's functional assessment included comprehensive, current information related to her behavioral management needs. 6. Individual #6's 3/7/08 IPP stated he was a 19 year old male. a. His IPP stated he would would attempt to run out the front door. The IPP stated "He normally does this to great [sic] people he sees pull up or to go to do something outside that interests him." However, his behavioral assessment, dated 3/08, stated he was non-compliant, would push and kick staff when directed to another choice when attempting to elope, and he would hit himself in	W 214		

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W 214	Continued From page 17 the face and attempt to bang his head on the ground. The "Function of the Behavior" section of the assessment stated he "uses this behavior to try to get home." The assessment also included an objective to decrease elopements to 1 per month for 6 consecutive months. No other information related to Individual #6's elopement behavior was included in the assessment. When asked about the assessment, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated additional information was not in the assessment but should be. b. Individual #6's behavior intervention plan, revised 3/08 stated Individual #6 engaged in SIB (biting, hitting, head banging). The plan stated if he attempted to bang his head, staff were to use a helmet for up to 2 minutes. However, his 3/08 behavior assessment did not include information related to the helmet use. When asked about the assessment, during an interview on 7/1/08 at 3:00 p.m., the QMRP stated the information related to the helmet was not included in the assessment but it should be. 7. Individual #4's behavior intervention plan, revised 10/4/07, stated she engaged in aggression (hitting, biting, pinching, scratching, kicking, head butting, and attempts to) and SIB (scratching self, hitting self, slapping self, pinching self, banging head, and attempts to). The plan stated if she was aggressive/self abusive and other interventions had not been effective, staff were to escort her to her room or another area away from others. The plan stated "Staff may use Mandt techniques (physical assist to stand or sit & the walking/moving restraint) to assist [individual #4] to an area away from	W 214		

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W 214	Continued From page 18 others." However, Individual #4's 10/2/07 behavioral assessment did not include information related to the restraints. When asked about the assessment, the QMRP stated, during an interview on 7/1/08 at 3:00 p.m., information related to the restraints was not included in the assessment but it should be. 8. Individual #7's 4/8/08 IPP stated he was admitted to the facility on 4/12/07. He was diagnosed with ADHD and had difficulty sitting or staying on task. His IPP further stated he would "express displeasure by whining, crying, screaming, turning his head away or pushing others away when he doesn't want to do something." Additionally, he would "occasionally drop to the floor to refuse, but is easily directed to stand again with verbal prompting." Individual #7's behavioral assessment, dated 4/8/08, stated he would "use the drop to the floor behavior as a way to avoid a task. Staff can usually get [Individual #7] to rise up off the floor with just verbal prompting and then holding out their hand. Brushing his teeth or combing his hair requires full hand over hand assistance and head stabilization. During this, [Individual #7] will scream and attempt to drop to the floor or attempt to otherwise remove himself from the area... [Individual #7] is also unable to remain focused on most tasks for more than a second or two." The function of the behaviors section of the assessment stated "[Individual #7's] behaviors seem to be escape motivated." The assessment did not include information regarding his inability to stay on task given his diagnosis of ADHD, as stated in his IPP. When asked about the assessment, the QMRP stated, during an	W 214		

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W 214	Continued From page 19 interview on 7/1/08 at 3:00 p.m., the assessment needed to be updated. The facility failed to ensure the individuals' behavioral assessments contained comprehensive information.	W 214		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure the individuals' IPPs included objectives to meet the needs for 2 of 8 individuals (individuals #5 and #8) whose behavioral assessments were reviewed. This resulted in a lack of program plans designed to address the needs of the individuals in areas most likely to impact their lives. The findings include: 1. On 6/27/08 at 12:10 p.m., individual #5 was observed sitting at the dining table eating lunch. At that time he was noted to be wearing a blue and white surgical mask around his chin. Individual #5's 8/3/07 IPP did not include information related to the mask. When asked about the mask on 6/27/08 at 4:20 p.m., the QMRP stated there were guidelines in place related to individual #5's spitting and the mask use. The guidelines/protocol, undated, stated the following:	W 227	**W 227 483.440(c)(4)** **INDIVIDUAL PROGRAM PLAN** The individual program plans will include specific objectives necessary to meet the clients needs. Behavioral assessments will be included in the IPP to ensure that the program address's all of the clients needs. The behavioral assessment will be cross referenced with the IPP to ensure that all objective's are included. This will be done for all 8 clients residing at Courtyard to ensure this deficient will not recur. To be completed by the QMRP, Administrator, and Behavioral Specialist by 09/21/08.	

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W 227	Continued From page 20 "[Individual #5] has a tendency to spit...[Individual #5] will spit while at the table, while he is near other residents and their belongings and throughout the day. At this time, we have found that [Individual #5] spits more often when he is agitated, he will also spit when there appears to be no triggering events. Due to our inability to predict when [Individual #5] will spit, we have developed a protocol to help [Individual #5] be more successful at reducing the number of times a day [Individual #5] contaminates the home." The protocol included the following staff instructions which were to be followed when Individual #5 engaged in spitting: - Staff were to ask Individual #5 to please stop spitting and tell him "since you spit, we have to put on a mask." - Staff were to place a mask on him which was to remain covering his mouth for 30 seconds with no incidents of spitting. - Once the mask had been in place with no incidents of spitting for 30 seconds, staff were to tell him "good job not spitting" and move the mask from his mouth to his chin. The protocol also stated the mask was to be replaced when soiled and Individual #5 could remove it after 30 seconds. If he did remove the mask it was to stay off unless he spit again. The "Mealtime" section of the protocol included the following instructions to staff: - Individual #5 was to be given the opportunity to eat with his peers. However, if he spit once while at the table for his meal, staff were to prompt him to stand up and go to the kitchen.	W 227		

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W 227	Continued From page 21 - Staff were to then direct him to eat at the kitchen counter to ensure the other individuals' food and utensils were not contaminated. The protocol stated staff were not to have individual #5 clean up any contaminated area as it escalated his spitting behavior. The protocol also stated "Remember, the mask is not part of a behavior plan, it is for the reduction of cross contamination...staff are to document the number of times per shift [individual #5] spits, [sic] on a behavior slip." When asked about the protocol, the QMRP stated, during an interview on 7/1/08 at 3:00 p.m., spitting was a problem when individual #5 was first admitted to the facility, but the episodes of spitting had gone to zero within the first week. However, 10 direct care staff were interviewed regarding the mask on 6/27/08 and 6/28/08. Staff stated the following: - He wears it when he spits but it is not an everyday thing. - He spits fairly often and we use the mask for a few seconds. - The mask is used when he spits. He leaves it over his mouth for a few seconds and then wears it pulled down around his chin for up to an hour based on how frequently he is spitting. - When he spits the mask is given to him. He puts it on for a few seconds, then it is thrown away. - We leave it on for a few minutes when he spits. Individual #5's IPP did not include an objective related to his spitting behavior. The facility failed to ensure specific objectives and formal plans had been developed to address individual #5's	W 227		

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W 227	Continued From page 22 behavioral needs. 2. Individual #8's 1/2/08 IPP stated he had autism and a history of maladaptive behaviors. His IPP stated he received Tenex (an antihypertensive drug) 2 mg 1 and 1/2 tablets each evening. His IPP further stated the psychotropic medication reduction plan for Tenex was based on Individual #8 averaging 8 hours of sleep per night for six consecutive months. However, Individual #8's IPP did not include a specific written objective related to his sleep. When asked if a specific objective had been developed and if the medication had been incorporated in to a plan to address Individual #8's sleep disturbances, the QMRP stated, during an interview on 7/1/08 at 3:00 p.m., there was nothing beyond the medication reduction plan. The facility failed to ensure specific objectives and formal plans had been developed to address Individual #8's sleeping disturbances.	W 227		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure the individual program plan described relevant interventions to support 1 of 1 individuals (Individual #4) whose supports were reviewed. This resulted in a lack of information being provided to staff. The findings include: 1. On 6/27/08 at 2:00 p.m., staff were observed	W 240	**W 240 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN** The individual program plan will describe all relevant interventions to support the individuals towards independence. all clients who have special instructions or special needs in different circumstances, for instance surgery, their will be s protocol put in place to ensure all staff will know what to do.	

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W 240	Continued From page 23 to carry Individual #4 to the van and place her inside. At that time staff was asked why Individual #4 was being carried. Staff stated Individual #4 had foot surgery and her foot sometimes bother her, so staff carried her. Individual #4's records as well as the staff communication log were reviewed. The communication log included an entry which stated she was weight bearing as tolerated. No other specific information related to her ability to ambulated, transfer, etc. was included in her record. When asked about guidelines/protocols related to Individual's #4's ambulation ability, transfer/carries, etc. based on her current needs as a result of the foot surgery, the LPN stated, during an interview on 8/27/08 at 4:25 p.m., there was no additional information to staff beyond what was written in the communication log. The facility failed to ensure Individual #4's IPP was updated to include relevant services and supports she required as a result of her foot surgery.	W 240	All staff will be in serviced and trained on all guidelines/protocols that are put in place. This will be done for all 8 clients that reside at Courtyard to ensure the deficient will not recur. To be completed by the LPN, QMRP, and Administrator by 09/21/08.	
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure techniques used to manage inappropriate	W 289		

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W 289	Continued From page 24 behavior were incorporated into the program plans of 1 of 8 individuals (Individual #5) whose behavioral assessments were reviewed. This resulted in interventions being used that were not included in the individual's program plan. The findings include: 1. On 6/27/08 at 12:10 p.m., Individual #5's was observed sitting at the dining table eating lunch. At that time he was noted to be wearing a blue and white surgical mask around his chin. Individual #5's 6/3/07 IPP did not include information related to the mask. When asked about the mask on 6/27/08 at 4:20 p.m., the QMRP stated there were guidelines in place related to Individual #5's spitting and the mask use. The guidelines/protocol, undated, stated the following: "[Individual #5] has a tendency to spit...[Individual #5] will spit while at the table, while he is near other residents and their belongings and throughout the day. At this time, we have found that [Individual #5] spits more often when he is agitated, he will also spit when there appears to be no triggering events. Due to our inability to predict when [Individual #5] will spit, we have developed a protocol to help [Individual #5] be more successful at reducing the number of times a day [Individual #5] contaminates the home." The protocol included the following staff instructions which were to be followed when Individual #5 engaged in spitting: - Staff were to ask Individual #5 to please stop spitting and tell him "since you spit, we have to put on a mask."	W 289	**W 289 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR.** All interventions used to manage inappropriate client behavior will be incorporated into the clients individual program plan. The behavior assessment will be revised and a behavior program written, and incorporated into the IPP. For interventions used to manage behaviors in any clients it will be incorporated into the IPP. this will be done for all 8 clients residing at Courtyard to ensure that the deficient will not recur. To be completed by the QMRP, And Administrator 09/21/08.	

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W 289	Continued From page 25 - Staff were to place a mask on him which was to remain covering his mouth for 30 seconds with no incidents of spitting. - Once the mask had been in place with no incidents of spitting for 30 seconds, staff were to tell him "good job not spitting" and move the mask from his mouth to his chin. The protocol also stated the mask was to be replaced when soiled and Individual #5 could remove it after 30 seconds. If he did remove the mask it was to stay off unless he spit again. The "Mealtime" section of the protocol included the following instructions to staff: - Individual #5 was to be given the opportunity to eat with his peers. However, if he spit once while at the table for his meal, staff were to prompt him to stand up and go to the kitchen. - Staff were to then direct him to eat at the kitchen counter to ensure the other individuals' food and utensils were not contaminated. The protocol stated staff were not to have Individual #5 clean up any contaminated area as it escalated his spitting behavior. The plan also stated "Remember, the mask is not part of a behavior plan, it is for the reduction of cross contamination...staff are to document the number of times per shift [Individual #5] spits, [sic] on a behavior slip." When asked about the protocol, the QMRP stated, during an interview on 7/1/08 at 3:00 p.m., spitting was a problem when Individual #5 was first admitted to the facility, but the episodes of spitting had gone to zero within the first week. However, 10 direct care staff were interviewed	W 289		

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W 289	Continued From page 26 regarding the mask on 6/27/08 and 6/28/08. Staff stated the following: - He wears it when he spits but it is not an everyday thing. - He spits fairly often and we use the mask for a few seconds. - The mask is used when he spits. He leaves it over his mouth for a few seconds and then wears it pulled down around his chin for up to an hour based on how frequently he is spitting. - When he spits the mask is given to him. He puts it on for a few seconds then it is thrown away. - We leave it on for a few minutes when he spits. The mask and removal from the dining table were being used as systematic interventions to address Individual #5's spitting behavior. The facility failed to ensure the use of the interventions had been incorporated into Individual #5's IPP.	W 289		
W 290	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Standing or as needed programs to control inappropriate behavior are not permitted. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure standing or as needed programs to control inappropriate behavior, in the absence of evidence to justify such usage, were not permitted for 1 of 8 individuals (Individual #2) whose behavioral interventions were reviewed. This resulted in interventions being incorporated into an individual's plan without justification for their use. The findings include:	W 290	**W 290 483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR** Standing or as needed programs to control inappropriate behavior's will be discontinued. All 8 clients BMP's will be re-evaluated to ensure that there is no standing or as needed programs. This will be done to ensure that this deficient will not recur. To be completed by the QMRP, And Administrator by 09/21/08.	

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W 290	Continued From page 27 1. Individual #2's 6/8/08 IPP stated he was diagnosed with profound mental retardation. His behavior intervention plan, dated 3/20/07, stated he engaged in behaviors which included self abuse (defined as biting himself and attempts to). The plan stated staff were to "follow the prompting hierarchy to get [Individual #2] to stop biting himself all the way up to Mandt technique for a bite release." The plan also stated if other interventions were ineffective, staff were to wrap the area on his hand that he was biting in such a manner as to allow him continued full use of his hand and fingers. Individual #2's behavior slips from 1/08 to 6/26/08 were reviewed and did not include documentation that the bite release technique or the wrap had been used. When asked during an interview on 7/2/08 at 9:00 a.m., the QMRP stated the wrap and the bite release had not been used in a "very long time." He stated the interventions had not been used since at least 6/07. The facility failed to ensure Individual #2's interventions were justified based on the current level (severity, intensity, duration, and frequency) of SIB he displayed.	W 290		

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 07/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYA	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W290.	MM177	MM177 16.03.11.075.09 Protection from Abuse and Restraint Refer to W290.	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W124.	MM196	MM196 16.03.11.075.10(c) Consent Of Parent or Guardian. Refer to W124.	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289.	MM197	MM197 16.03.11.075.10(d) Written Plans Refer to W289	
MM203	16.03.11.075.12(a) Treated with Consideration Treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; and	MM203	MM203 16.03.11.075.12(a) Treated with Consideration Refer to W130.	

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FACILITY STANDARDS

Bureau of Facility Standards

Teresa Carpenter — Admin — 7/16/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

PRINTED: 07/08/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 07/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM203	Continued From page 1 This Rule is not met as evidenced by: Refer to W130.	MM203		
MM209	16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209	MM209 16.03.11.075.15 Right to Personal Items Refer to W137	
MM622	16.03.11.230.05(d) Proper Instruction Instruction in the proper management of seizure disorders, physical handicaps, special communication needs and physically injurious behaviors. This instruction must be provided before personnel are assigned to work with individuals who may be affected by the above disorders, handicaps, needs and behaviors; and This Rule is not met as evidenced by: Refer to W193.	MM622	MM622 16.03.11.230.05(d) Proper Instruction. Refer to W193.	
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement.	MM725	MM725 16.03.11.270.01(b) QMRP Refer to W159.	

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 07/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	815 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM725	Continued From page 2 This Rule is not met as evidenced by: Refer to W159.	MM725		
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729	MM729 16.03.11.270.01(d) Treatment Plan Objectives Refer to W227	
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	MM730 16.03.11.270.01(d)(i) Refer to W214	
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by: Refer to W240.	MM861	MM861 16.03.11.270.08(f)(iii) Periodic Review Refer to W240.	

Addendum to Complaint Survey Conducted at Courtyard July 2nd, 2008.

W 124 A QA system will be put into place to ensure this deficit will not recur, this will be done Quarterly by the Behavioral Specialist.

W 159 QA system will be put into place to ensure this deficit will not recur, every quarter the QMRP books will be checked and cross referenced to include that all weights are looked at and assessed. This will be done Quarterly by the Behavioral Specialist and Administrator.

W 193 Monthly Observations will be conducted and notes kept as to the observation, this will be done by the Administrator and RSC.

W 214 Quarterly checks will be conducted, monitoring will be done to make sure the IPP'S, Behavioral Assessments, and BMP'S all match with no missing information. This will be done by the QMRP, Behavioral Specialist, and the Administrator.

W 227 All assessments will be monitored and cross-referenced so all information will be the same, this will be done Quarterly by the QMRP, Behavioral Specialist, and the Administator.

W 240 Please refer to W193.

W 289 Please refer to W193.

W 290 Quarterly checks will be done, all QMRP books will be monitored and cross-referenced to ensure that no as needed programs or no standing programs will be missed. This will be done by the Behavioral Specialist, QMRP, and the Administrator.

Teresa Carpenter
Administrator
7/29/08